VERMONT

AGENCY OF HUMAN SERVICES

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

October 31, 2019

Mr. Bradford Ellis, Administrator
Vernon Green Nursing Home
61 Greenway Drive
Vernon, VT 05354-9474

Dear Mr. Ellis:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **September 18, 2019**. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M Cota RN

Pamela M. Cota, RN
Licensing Chief

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475008	A. BUILDING _____ B. WING _____	09/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERNON GREEN NURSING HOME	61 GREENWAY DRIVE VERNON, VT 05354

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E 000	Initial Comments The Division of Licensing and Protection conducted an unannounced onsite survey regarding emergency preparedness on 9/16/2019 through 9/18/2019. The facility was found to be in substantial regulatory compliance regarding emergency preparedness planning.	E 000	Allegation of Substantial Compliance Vernon Green Nursing Home, herein after sometimes "facility", has and continues to be in substantial compliance with 42 CFR Part 483 subpart B. Vernon Green Nursing Home has or will have substantially corrected the alleged deficiencies and achieved substantial compliance by the date specified herein.	
F 000	INITIAL COMMENTS An unannounced on-site re-certification survey was conducted by the Division of Licensing and Protection on 9/16/19 through 9/18/19. The following regulatory deficiencies were identified:	F 000	This Plan of Correction constitutes Vernon Green Nursing Home's allegation of substantial compliance such that the alleged deficiencies cited have been or will be substantially corrected on or before October 12, 2018.	
F 657 SS=F	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs	F 657	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To continue to remain in substantial compliance with state and federal regulations, Vernon Green Nursing Home has taken or will take the actions set forth in this plan of correction. **F 657** The facility has and will continue to ensure that it has established and will maintain the timing and revision to resident care plans. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** Residents are seen on a regular basis by their attending physicians. The 15 resident cited in the finding did have physician documentation in proximity to the resident's care review date. **Resident #1** care plan review was on 09/30/2019 and was seen by the physician on 09/23/2019 and 09/30/2019;	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Executive Director | 10/15/2019

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 657	Continued From page 1 or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to provide evidence of the participation of all required Interdisciplinary Team (IDT) meeting members during care plan meetings, and for preparing comprehensive care plans for 15 of the 24 sampled residents. Residents #1, 3, 4, 5, 9, 13, 14, 22, 23, 24, 33, 39, 44, 45 and 50. Findings include: Record reviews conducted by the survey team during the re-certification survey between 9/16/19 and 9/18/19 failed to produce evidence that the IDT included all required members of the team, as required per Centers for Medicare Services (CMS), to participate in the comprehensive care plans of the above identified residents. Per interview with the Registered Nurse Unit Manager on A wing, on 09/18/19 at 11:12 AM, s/he did not think that the physician reviewed the care plans before the meetings and the physicians have not attended care plan meetings that s/he has attended. In an interview with the Director of Social Services (DSS) on 9/18/19 at 5:02 PM, s/he confirmed that there is no evidence that the physicians are part of the IDT. The DSS further stated that the physician will only attend a care plan meeting on occasion and only if something comes up as a concern that the physician needs to address, such as a discharge. The DSS confirmed at this time that the physician is not part of the IDT and they do not review the care plans and/or give input to the comprehensive	F 657	Continued from page 1 #3 care plan review was on 09/08/2019 and was seen by the physician on 08/15/2019 and 09/26/2019; #4 care plan review was on 09/02/2019 and was seen by the physician on 07/18/2019 and 09/09/2019; #5 care plan review was on 09/08/19 and was seen by the physician on 09/03/2019 and 09/09/2019; #9 care plan review was on 09/20/2019 and was seen by the physician on 08/15/2019 and 09/26/2019; #13 care plan review was on 09/06/2019 and was seen by the physician on 07/15/2019 and 10/07/2019; #14 care plan review was on 09/23/2019 and was seen by the physician on 09/16/2019 and 09/20/2019; #22 care plan review was on 07/28/2019 and was seen by the physician on 07/11/2019 and 08/15/2019; #23 care plan review was on 09/16/2019 and was seen by the physician on 08/15/2019 and 09/26/2019; #24 care plan review was on 09/23/2019 and was seen by the physician on 09/03/2019 and 10/07/2019; #33 care plan review was 08/05/2019 and was seen by the physician on 07/08/2019 and 09/03/2019; #39 care plan review was on 08/19/2019 and was seen by the physician on 08/05/2019 and 09/03/2019; #44 care plan review was on 08/22/2019 and was seen by the physician on 07/01/2019 and 09/03/2019; #45 care plan review was on 08/22/2019 and was seen by the physician on 08/20/2019 and 09/30/2019; #50 was 08/27/2019 and was seen by the physician on 08/13/2019 and 09/09/2019.	

Physicians will continue to participate in residents' plan of care and will be required to acknowledge (with their signature) their participation in the residents' care planning as part of the Interdisciplinary Team. 10/25/19

How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.

All residents have the potential to be affected by this alleged deficient practice. 09/18/19

What measures will be put into place or what systemic changes you will make to endure that the deficient practice does not recur.

Process has been implemented to continue to provide attending physicians with comprehensive care plans for their residents. Physicians will continue to participate in residents plan of care and will be required to acknowledge (with their signature) their participation in the residents care planning. 10/25/19

How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.

The Director of Nurses/designee will provide ongoing monitoring of this process to ensure compliance. Results of this audit will be brought to the Quality Assurance Performance Improvement committee meeting and/or until 100% compliance is achieved. 10/15/19

F657 POC accepted 10/31/19 PMcetaRN

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F 657	Continued From page 2 care plan.	F 657		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, direct observation and staff/resident interviews, the facility failed to ensure that the environment was free of accident hazards for 1 applicable resident, (Resident #24). The findings are as follows: As the evidence demonstrates below, after Resident #24 sustained a burn from spilling hot coffee, the facility failed to adequately address all areas of potential hazards for Resident #24 to prevent further accidents. Per medical record review, Resident #24 suffered burns on 08/29/19 to his/her right leg extending from the top of the resident's thigh to the back of the right knee. The resident reported spilling coffee while independently self-propelling his/her wheelchair back to his/her room. The burn was assessed by the nursing staff; the physician was notified and ordered daily of cleansing and dressing the wound until healed. Per review of the physician's progress note dated 09/03/19, reads, "a few days ago resident was drinking coffee and it spilled on self, resulting in erosion of the skin on the thigh and vesicle [blister]	F 689	**F689** The facility has and will continue to ensure that residents are free of accident hazards. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** Resident receives hot beverages in mugs that have plastic lids that prevent spillage. Staff were educated on 08/29/2019, 08/30/2019, 09/25/19 and continue to be educated on monitoring for hot beverages being transported by residents. **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** All residents have the potential to be affected by this alleged deficient practice. **What measures will be put into place or what systemic changes you will make to endure that the deficient practice does not recur.** Staff have been educated on the monitoring of residents with hot liquids/food items that may spill. Staff have been educated on proper documentation to show their interventions with resident regarding the transportation of hot beverages. Residents will be monitored for transportation of hot beverages/food items that have the potential for burns and be assisted with the delivery of hot items.	09/25/19 09/18/19 09/25/19

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F 689	Continued From page 3 formation. The fluid filled vesicle's opened, drained and are beginning to heal. Burn is superficial and does not extend to the dermis". Per interview on 09/17/19 at approximately 1 PM with the resident and a family member, the resident denies any pain or discomfort at present and voiced that s/he is to blame for spilling the coffee on him/herself. Per review of the Minimum Data Set assessment (MDS), a federally mandated assessment dated 07/29/19, the resident is identified as having cognitive deficits and often refuses to allow staff to assess him/her. S/he requires supervision with locomotion on and off the unit; and needs supervision and set up for eating. On 08/29/19, as a result of this incident, the care plan was updated and indicated that nursing is to ensure lids and straws are used at all times while drinking coffee. Education was provided to the LNA staff related to the management of transporting hot beverages for Resident #24 on 08/29/19 and on 08/30/19 regarding transporting hot liquids from one location to another by residents. Nurses notes identify on 08/29/19 at 4:30 PM (2 hours after notification about the initial burn), the resident carried his/her hot soup and coffee after supper on his/her lap back to his/her room. Staff offered to transport, but the resident refused. There is no evidence in the nurses notes that staff provided education of risks at the time of refusal of assistance. There are also instances documented in the nurses notes identifying the resident requesting soup or coffee to be heated during the overnight shift and early mornings. There is no evidence that temperatures of the heated coffee or soup were monitored or checked	F 689	Continued from page 3 **How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.** The Director of Nurses/designee will provide ongoing monitoring of this process to ensure compliance. Results of this audit will be brought to the Quality Assurance Performance Improvement committee meeting and/or until 100% compliance is achieved. F689 POC accepted 10/31/19 PMcotaRN	10/15/19

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F 689	Continued From page 4	F 689		

prior to delivery to Resident #24 during the overnight shift.

The surveyors with the Administrator, Food Service Director and the Director of Nurses (DNS), checked the temperatures with a calibrated digital thermometer, of hot water and hot coffee during the evening meal on 09/16/19, on 09/17/19 all three meals were checked and on 09/18/19 breakfast and lunch liquids were checked. The results identified black coffee and hot water temperatures varied from as high as 164 degrees to as low as 142 degrees Fahrenheit. Through the investigation, it was discovered that temperatures of hot liquids are not routinely checked by facility staff prior to serving residents.

On 09/17/19 at 7:37 AM, the surveyor observed twelve residents eating breakfast in the activity room across from the nurses' station on A-Wing. LNA staff were observed to be in and out of the room and the Licensed Practical Nurse (LPN) was administrating medications. At 8:00 AM, unsupervised, Resident #24 placed a full cup of water and hot coffee upon his/her lap and propelled him/her-self approximately 20-25 feet to his/her room. The surveyor witnessed the hot coffee in the resident's lap had spilled out of the lid onto his/her thigh. At 8:05 AM, the LPN confirmed that the resident's pants at the knee area was wet and removed the cup of coffee from the resident's room. The surveyor in the presence of the LPN tested the coffee with a calibrated digital thermometer and it registered 122 degrees Fahrenheit. As a result of the second incident that was brought to the facility's attention by the surveyor, Resident #24 was provided with hard plastic spill proof mugs, that

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F 689	Continued From page 5 enables him/her to independently transport coffee at any time without the risk of spillage.	F 689	**F812** The facility has and will continue to ensure that it has established and will maintain food safety requirements.	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review the facility failed to ensure that food was stored in accordance with professional standards for food service safety. Findings include: 1. Per review of the facility's temperature logs for the refrigerators and freezers, it was noted that on the B-Wing unit the supplement refrigerator was consistently registering temperatures above 40 degrees from April 2019 through August 2019. On 9/17/19 at 4:15 PM, the surveyor accompanied the Food Service Director on a tour	F 812	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** On 09/17/19, it was determined that the thermometer in the refrigerator was reading higher than the actual refrigerator temperature. A new thermometer was located in the refrigerator. 11-7 nursing staff were educated on the need to record the refrigerator temperature in the refrigerator's monthly temperature log. **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** All residents have the potential to be affected by this alleged deficient practice. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;** The 7-3 B-Wing Charge Nurse will insure the temperatures for this refrigerator are accurately recorded on the posted log by the nursing staff each day; that nursing staff will be retrained to notify their supervisor and the maintenance staff when refrigerator temperatures are out of the stated range; when to move product to another refrigerator when this happens and the reasons these procedures are important	09/17/19 09/18/19 09/18/19

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F 812	Continued From page 6 to the B-wing unit and observed that the refrigerator temperature was not checked on 9/1, 9/2, 9/3, 9/4, 9/16, and 9/17/19; and that when the temperature had been checked in September of 2019, it was over 40 degrees. The refrigerator contained soda, juice, and Boost supplements. It also had an opened container of thickened dairy beverage. The Food Service Director confirmed that the thickened dairy beverage should have been kept at a temperature of 40 degrees or less; and that the refrigerator had been out of temperature range for over five months. S/he stated that s/he was unsure who was responsible for acting upon the elevated temperatures. Per interview on 4/17/19 at 4:30 PM with the Director of Nursing (DNS), s/he stated that it was the night nurse's responsibility to check the refrigerator temperature and that s/he was not aware that the refrigerator's temperature had been out range for "all of these months".	F 812	Continued from page 6 **How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.** The Director of Nurses/designee will provide ongoing monitoring of this process to ensure compliance. Results of this audit will be brought to the Quality Assurance Performance Improvement (QAPI) meetings and/or until 100% compliance is achieved. F812 POC accepted 10/31/19 pmcotaRN	10/15/19